

Memory Clinic Health Questionnaire

Client name:

Date of birth:

Please make sure you complete this pre-assessment before your appointment.

The nurse will review this assessment with you at your appointment.

Annual Health Check

Date:

Blood test

Date:

Eye check-up

Date:

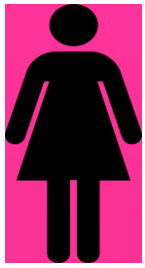
Dental check-up

Date:

Other health needs:

<u>Female:</u>

Cervical screening



Date:

Breast (Mammogram)

Date:

<u>Male:</u>

Prostate

Date:

Testicles

Date:

Have you had a MRI or CT scan?

Yes or No (please circle)

Do you need support to access your health check-ups?

Yes or No (please circle)

If you have answered yes:

What do you need support with?

Thank you for taking the time to complete your pre-assessment form.

If you need any help to complete your form please contact the Community Learning Disability Team on 01270 656 335.